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Home Health ICD-9/ICD-10 Alert

CODING COMPLIANCE: BUILD ACCURACY, SAVE TIME WITH THIS 4-STEP AUDIT PROCESS

Spend more time on billing audits, less on compliance, say experts.

Conducting audits on 100 percent of your charts won't guarantee 100 percent compliance ...quot; and this overkill could be taking your focus away from better billing practices. Use these audits to examine the big picture and use the time you save to focus on billing audits, say experts.

Reality: Even if your agency audits every single chart for compliance, surveyors will still manage to find something wrong, says **Karen Vance, OTR**, with **BKD** in Springfield, MO. You can save time by reviewing a random sample for compliance--and put the saved time to better use by establishing a thorough billing audit process.

Benefit: An audit can uncover a variety of areas for improvement, says **Ann Zeisset, RHIT, CCS, CCS-P** with the **American Health Information Management Association** in Chicago, IL. Some trends or patterns that could be potential risk areas include:

• Code choices that aren't supported by documentation;
• Not reporting ICD-9 codes for diagnoses included in the documentation;
• Violations of official coding guidelines;
• Not being compliant with third-party payer directives; and
• Codes assigned but not reported on the claim form.

Make the most of your audit time by looking for trends and patterns, suggests Vance. These types of compliance audits can be done on a quarterly basis, she says.

Process Simplifies Your Job

These simple steps can help you to build an effective and time-saving compliance audit process:

1. Select a random sample of charts to audit. Organize charts by dates of service and then select every fifth chart, suggests Zeisset.

2. Perform a base-line audit once you've established your sample. Check each chart for coding and billing errors. Your sample should include records that involve various payers, nurses and physicians, says Zeisset.

Example: You find that staff are using the diagnosis 781.2 (Abnormality of gait) frequently to support therapy. However, the audit reveals that this diagnosis is being used for gait problems because of the pain of arthritis or lower back pain and substituted for long-term diagnoses when a long-term diagnosis may have been more appropriate.

3. Follow through. After you have conducted an audit and created a plan to address any patterns or trends, make certain you follow through and make those improvements, says Zeisset. For instance, you might educate your staff on when it's appropriate to use symptom codes like abnormality of gait and how to ensure that documentation supports their use.

4. Monitor your progress. Develop a monitoring process. Measure compliance and clinicians' response to training about the findings, as you continue to monitor any risk areas the audit uncovered, Zeisset says.

Establish A Claims Auditing Process

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While quarterly compliance audits can focus on a sample percentage of charts, Vance recommends auditing all of your claims before submitting them. This is one area where auditing 100 percent of your records can pay off.

But the key to making billing audits work is to establish communication between the person doing that audit and the person doing the billing, says consultant **M. Aaron Little** with **BKD.**

In many home health agencies, the end of an episode is both the biller's cue to bill for the final claim and the chart reviewer's cue to review the chart, says Little. Often there's no coordination between the two departments to make sure that the chart is reviewed before the claim gets billed. This lack of communication can lead to all kinds of problems.

Problem: The chart reviewer finds an error in the way the diagnoses were scored on the OASIS and coded on the original plan of care. She does a correction. Depending on how the software does that correction, it may not carry over to the claim, says Little. Now there's a discrepancy between the ICD-9 codes on the claim and the documentation. If no one is looking at the claim, how do you know that it's right?

Example: The chart reviewer finds from the documentation in one chart that 781.2 (Abnormality of gait) coded in M0245, should have been coded as 332.0 (Parkinson's disease) in M0230 because both nursing and therapy were being provided for a worsening of the Parkinson's.

The original coding gives you 11 diagnosis points. But the more accurate diagnosis--Parkinson's--adds 20 points. The coder may initiate the process to correct the OASIS, but if that information does not get forwarded to the biller, the biller will submit the claim with a HIPPS code reflecting the 11 points for abnormality of gait.

Solution: Create a formalized communication process between billing and auditing staff, advises Little. For example, the biller knows that the agency has 10 episodes they need to bill for this week, because in the past week 10 episodes ended either due to discharge or to reaching day 60. She creates a list of these claims for her own reference and then prints out the claims and gives them to the auditors reviewing the charts. Once the chart auditors have reviewed the charts to make sure everything is in order, the auditor lets the biller know that she can go ahead and send the bills.

Note: See "Avoid Undue Scrutiny By Keeping Diagnoses Accurate," later in this issue, for more on how billing audits can save your agency both time and money.

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